



2318 Pass Road, Suite 9, Biloxi, MS 39531

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

SS# _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (_____) _____ Alt. Phone #2 (_____) _____

Employer/School _____ Employer/School Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (_____) _____

RESPONSIBLE PARTY

Name of person _____

Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No Email _____ Cell Phone (_____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY (Continued)

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

Any other concerns? _____

How often do you floss? _____

How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | Yes | No | Yes | No | Yes | No | Yes | No |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | | Congenital Heart Lesions | | Hernia Repair | | Shortness of Breath | |
| Arthritis, Rheumatism | | Cortisone Treatments | | High Blood Pressure | | Skin Rash | |
| Artificial Heart Valves | | Cough, Persistent | | HIV/AIDS | | Stroke | |
| Artificial Joints, Pins, etc. | | Diabetes | | Intellectual Delay | | Swelling of Feet or Ankles | |
| Asthma | | Epilepsy | | Jaw Pain | | Thyroid Problems | |
| Autism | | Fainting | | Kidney Disease | | Tobacco Habit | |
| Back Problems | | Glaucoma | | Liver Disease | | Tonsillitis | |
| Bleeding Abnormally | | Headaches | | Mitral Valve Prolapse | | Tuberculosis | |
| Blood Disease | | Heart Murmur | | Pacemaker | | Ulcer | |
| Cancer | | Heart Problems | | Radiation Treatment | | Venereal Disease | |
| Chemical Dependency | | Hemophilia | | Respiratory Disease | | | |
| Chemotherapy | | Hepatitis | | Rheumatic Fever | | | |
| Circulatory Problems | | | | Scarlet Fever | | | |

LIST MEDICATION YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS:

ALLERGIES:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Amanda McMurphy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.